The Impact of Pay for Value on Credentialing and Privileging

Session Code: TU10
Time: 10:00 a.m. – 11:30 a.m.
Total CE Credits: 1.5
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What’s driving healthcare reform?

We spend almost twice as much as every other industrialized nation ($9,200 per capita) with relatively weak quality metrics to show for it (39th infant mortality, 36th life expectancy etc.)
We tolerate an unacceptable variation in quality, safety, service, and cost (up to 1000%)
Our national debt is $15.2 trillion with a virtual debt of $62 trillion
GAO-To balance the budget by 2040-cut federal spending by 60% or raise taxes 2.5 times

Don’t wait for a political solution...

“Healthcare reform (transformation) is an economic problem in the guise of a political conflict.”

----Your Humble Speaker
Consumers are moving forward

Global competition for world class quality, safety, service at the lowest possible cost

Medical Tourism is the fastest growing industry in healthcare (2006-2012: $20 billion to $120 billion and expected to double every two years)


Typical story:

Paul H., Texas: Executive needing meniscus surgery of knee. Couldn’t find facility to do it under $32,000 or with epidural. Went to JCI accredited hospital in Monterrey, Mexico and paid $6,200 (including first class travel/accommodations/nursing) for Texas trained surgeon/anesthesiologist to perform procedure under epidural

What do you consider your service area? Your home town, your region, or the world?

What are large employers doing?

1. Greater cost sharing from defined benefit to defined contribution towards purchase on public/private insurance exchanges
2. Create and contract through narrow/tiered networks for high quality/low cost providers
3. Provide disease management programs for high risk pool and health wellness programs for all to reduce costs and enhance productivity
4. Reference based prices for high cost procedures/care
5. Utilize navigators/registries to guide employees through the system
6. Create and contract through ‘centers of excellence’ bundled payment program
Domestic Medical Tourism

Walmart’s “Centers of Excellence” for all heart, spine, and transplant surgeries for its 2.2 million associates ($466.1 billion in revenues):
1. Cleveland Clinic, Cleveland, OH
2. Geisinger Medical Center, Danville, PA
3. Mayo Clinic in Rochester, MN Scottsdale, AZ/Jacksonville, FL
4. Mercy Hospital Springfield, Springfield, MO
5. Scott and White Memorial Hospital, Temple, TX
6. Virginia Mason Medical Center, Seattle, WA

Is there a difference in performance when physicians work together?

<table>
<thead>
<tr>
<th>Measurement</th>
<th>MHMD CI Physicians</th>
<th>Crimson-All Hospitals</th>
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</thead>
<tbody>
<tr>
<td>LOS</td>
<td>4.52 (5%)</td>
<td>4.74</td>
</tr>
<tr>
<td>HAIs</td>
<td>0.68% (91%)</td>
<td>7.56%</td>
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<tr>
<td>General Complications</td>
<td>1.24% (66%)</td>
<td>2.82%</td>
</tr>
<tr>
<td>30 Day Readmissions</td>
<td>5.92% (43%)</td>
<td>10.38%</td>
</tr>
<tr>
<td>Mortality</td>
<td>1.95% (23%)</td>
<td>2.52%</td>
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Third party payers are moving forward

What AETNA did when it saw this data:
1. Requested to negotiate a new contract with MHMD
2. Offered a 8% increase in FFS payment with a guarantee of 3% next year minimum
3. With 10% movement of ‘share’ to the system, committed $7.5 million to physician pool and $8.0 million to system pool in bonuses
4. Committed to invest in a comprehensive marketing program to compete with United and BCBS
How third party payers are incentivizing beneficiaries:

Anthem Blue Cross and Blue Shield Compass Smart Shopper 800 Line (NH):
- CT of the abdomen with contrast ($750-$2,839)
- MRI of the knee ($681-$3,597)
- Digital mammography ($231-$818)
- Ultrasound of the pelvis ($177-$741)
Pick a low cost option, Aetna pays the beneficiary $75-$150
Pick a higher cost option, beneficiary pays the total cost up to the deductible/co-payment

How third party payers are incentivizing beneficiaries:

Anthem Blue Cross and Blue Cross Site of Service Benefit (NH):
- Get surgery at an ambulatory surgical center (ASC), the beneficiary pays $75-$100 total
- Get surgery at a hospital, the beneficiary pays the cost up to the deductible and co-payment
- Get laboratory services at Quest Diagnostics/LabCorp/Converge Diagnostic Services/NorDx, the beneficiary pays $10
- Get laboratory services at a hospital, the beneficiary pays the cost up to the deductible and co-payment

Value-Based Purchasing Roadmap

CMS quality-based payment initiatives will put more than 12% of payment at risk

<table>
<thead>
<tr>
<th>Year</th>
<th>Reporting Hospital Quality Data</th>
<th>Value-Based Purchasing</th>
<th>Readmissions</th>
<th>Hospital-Acquired Conditions</th>
<th>Meaningful Use</th>
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<tr>
<td>2011</td>
<td></td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
<td>5%</td>
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<td>2012</td>
<td></td>
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<td>2%</td>
<td>2%</td>
<td>3%</td>
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<tr>
<td>2013</td>
<td></td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
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<tr>
<td>2014</td>
<td></td>
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<td>2015</td>
<td></td>
<td>1%</td>
<td>3%</td>
<td>4%</td>
<td>5%</td>
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<tr>
<td>2016</td>
<td></td>
<td>1%</td>
<td>3%</td>
<td>5%</td>
<td>6%</td>
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<td>3%</td>
<td>6%</td>
<td>7%</td>
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<tr>
<td>2018</td>
<td></td>
<td>1%</td>
<td>3%</td>
<td>7%</td>
<td>8%</td>
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<tr>
<td>2019</td>
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<td>3%</td>
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<td>9%</td>
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<td>2020</td>
<td></td>
<td>1%</td>
<td>3%</td>
<td>9%</td>
<td>10%</td>
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2% of APU
2%
3%
1% 1.25% 1.5% 1.75% 2%
1% 2% 3% 3% 3%
1% 2% 3% 4% 5%
Revenue Side: Value Based Purchasing FY 2014

1.25% Base operating DRG payments

Process of Care Measures (45% Weight)

HCAHPS Composites (30% Weight)

Outcomes (25% Weight)

Performance attainment and improvement will determine total hospital reimbursement

What is the mandate of healthcare reform?

World class quality, safety, and service at half the cost!

Are your physicians and practitioners aligned to achieve those goals?

What are you measuring today?

- Core/SCIP measures?
- Compliance with clinical/functional pathways?
- Adverse behavioral or administrative events?
- Patient or administrative complaints/referrals?
- All deaths or complications?
- All unexpected returns to the…?

What is the challenge with all of these?
What is regulatory quality?

• Core measures
• SCIP measures
• Specialty specific measures (e.g. STS, ACC etc.)
• NQF ‘never events’
• Patient safety measures
• HEDIS measures

Why are these important and what do you want to do with them?

Hardwire regulatory quality!

• Clinical and functional pathways
• Standardize communications (e.g. SBAR) in high risk situations
• Manual checklists (pre-software)
• Decision support software and default functions
• Clinical and business analytics to monitor for variance (audit!)
• Many organizations are hitting 100% all of the time!

Regulatory quality is necessary and insufficient!

• You can no longer differentiate yourself based upon 100%tile for ‘core/SCIP etc. measures’; it is assumed and expected!
• Our increasingly mobile society will travel anywhere to find high quality and lost cost care
• How will you differentiate yourself from everybody else?
What is the typical ‘disconnect’?

- There is little organizational alignment between the performance goals/objectives of governance, management, physicians, and staff
- Performance measures have little to do with the major quality/safety/service issues
- Executive management incentivizes physicians to defeat the organization’s strategic initiatives (e.g. wRVUs)

Step 1: Create a MS Strategic Plan

- Co-authored by physician and executive leaders and approved by the governing board
- Articulates and prioritizes key medical staff goals/objectives for the coming year and beyond consistent with organizational strategic priorities

Step 2: Create a MS Operations Plan

- Audit the current organizational structures (e.g. committees, leadership skill set, time spent performing functions etc.) to determine if it will optimally serve the MS’ goals/objectives
- Redesign the MS structures/processes to ensure optimal performance (outcomes)
- Create tactics to accomplish specific goals/objectives
Step 3: Articulate specific performance expectations

- Categorize by performance dimension (e.g., patient care, professionalism etc.)
- Tie directly to prioritized strategic operational goals and objectives
- Should be specialty specific and generic
- Discuss at department/general/service line meetings to secure agreement and ‘buy in’
- All performance expectations should be memorialized in contracts

Step 4: Create Performance Metrics with Targets

- Delegate to MS Quality/Peer Review Committee with input from departments/service lines
- Separate those measures that will or won’t be considered for credentialing/privileging and peer review
- Ensure that metrics and targets are consistent with organizational strategy

Step 5: Create MS and MS Committee Work Plans to support Performance

- The work of the medical staff should be consistent with what it is trying to accomplish (present/future) not what it accomplished in the past
- All physician/physician leader performance should support and be supported by executive management and governance
Step #6: Measure Performance

- Ensure that data is credible before ‘going live’
- Best practice: Data Management Committee for larger organizations/systems
- Emphasis should be on trends and patterns and not on statistical significance

Step #6a: Imbed the Performance Management Process in all contracts!

- The medical staff bylaws should inform all contracts (e.g. “When the bylaws and contract are in conflict, the contract shall prevail”)
- The contracts should inform the medical staff bylaws (e.g. clean sweep provisions? etc.)
- Coordinate performance management between employer and medical staff

Step #7: Provide supportive and timely feedback

- Emphasis on improvement (PI) and not the identification of negative outliers (QA)
- Supportive, objective and data driven
- Collaborative between practitioner and physician leader (both should be accountable!)
- Address potential conflicts and conflicts of interest
- This requires training and expertise!
Step #8: Create Improvement Plans for Marginal Performance

- Does the practitioner understand the ‘why’?
- Measurable expectations with specific timeframe and mutual accountabilities
- Ensure support for individuals and the ‘system’ (self-fulfilling prophecy)
- Explicit positive and negative consequences for outcome

Remember David Marx’s “Just Culture”

1. Good practitioner/unusual occurrence: console and address ‘system’ issues
2. Good practitioner/mode of not following a rule: educate (the ‘why’), re-train and only utilize progressive discipline as a last resort
3. Chronically non-compliant practitioner or egregious event: immediate progressive discipline up to corrective action as needed (“imminent danger”)

Step #9: Create MS Scorecards/Dashboards to Report Performance

- Part of the President of the MS’s monthly report to the board
- Part of OPPE/FPPE
- Remember to focus on both sides of the curve (hardwire outstanding performance and improve marginal performance)
- Performance may be appropriately reported within teams (e.g. hospitalists, service line etc.)
Step #10: MS Performance informs the Credentialing and Privileging process

- Part of the internal analysis to develop the updated credentialing/privileging policies and procedures
- Part of ongoing evolution of credentialing and privileging criteria
- Part of strategic medical staff development planning

Strategic medical staff development plan

Board approved policy that recommends the specific:

a. Numbers of practitioners for each clinical specialty
b. Qualifications required within each clinical specialty
c. Economic relationship within each clinical specialty (e.g. employed, member of service line, exclusive agreement etc.)
d. Organizational fit (e.g. organizational culture, values, goals, objectives)
e. Personal and professional fit (compatibility of practitioner with organization)

Economic Credentialing:

- The use of ‘non-competence’ related criteria for membership on a medical staff or in a healthcare organization
- Point of contention with AMA, physician groups, attorneys, and healthcare organizations (e.g. Murphy v. Baptist Health and Rosenblum v. Tallahassee Memorial Regional Medical Center, Friedman v. Delaware County Memorial Hospital-2009)
- Growing necessity due to evolution of ‘at-risk’ reimbursement methodologies (e.g. shared savings)
- Best approach is to always link ‘economic’ criteria to quality (e.g. utilization management), community need and maintain a clear moral compass with regard to patient and community interests
Sample ‘economic’ credentialing and privileging criteria

Cardiologist:
• Complete an accredited residency in internal medicine and two year fellowship in interventional cardiology
• Board certified in cardiology
• Employed by hospital based cardiology group and service line
• Willing to comply with all medical staff and organizational requirements
• Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the cardiology group and service line

Family Physician:
• Complete an accredited residency in family medicine
• Board certified in family medicine
• Employed by hospital based patient centered medical home and integrated practice
• Willing to comply with all medical staff and organizational requirements
• Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the PCMH and integrated practice

Work with your legal counsel!
• Can the board open and close categories of membership and clinical privileges on the medical staff based upon community need?
• Can the board restrict membership and privileges to those party to exclusive agreements and contracts?
• Can management create ‘clean sweep’ provisions in all practitioner contracts?
• Can the medical staff and board create credentialing/privileging criteria based upon willingness to comply with EBM and practices?
The Future Medical Staff:
1. Completely employed or contracted practitioners in a closed system
2. High level of professionalism/service with clear demarcation between professional and personal life
3. Professional leaders at all levels of the organization
4. Patient centric management environment with complete integration of operations and clinical services (support logistics + in/out patient services)
5. Consolidated system of high reliability, continual improvement, and elimination of non-value added variation

General Principles:
1. Credentialing and privileging criteria should support your organization’s strategic quality, safety, service and cost-effective initiatives
2. Performance metrics should support your key credentialing/privileging criteria and should be negotiated between physicians, management, and the board
3. The credentialing/privileging process should play an active and proactive role in performance management (reappointment is too late!)

Questions? Thanks for your participation!

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